Information Summary and Recommendations

Dental Anesthesia
Mandated Benefits Sunrise Review

February 1999

Health Systems Quality Assurance

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Dental Anesthesia
Mandated Benefits Sunrise Review

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For more information or additional
copies of this report contact:

Office of Health Services Development
PO Box 47851
Olympia, Washington 98504-7851

Phone: (360) 236-4622
Fax: (360) 236-4626

Mary Selecky
Acting Secretary of Health

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EXECUTIVE SUMMARY

PROPOSAL FOR SUNRISE REVIEW

House Bill 2540, an act relating to anesthesia and hospital charges for dental care, requires health plan reimbursement for the necessary use of general anesthesia and hospital care for a covered person who (1) is a child under age six; (2) is severely disabled; or (3) has a medical condition requiring hospitalization or general anesthesia for dental care treatment, provided that such services are delivered upon the recommendation of the patient's physician. Prior authorization may be required in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

The intent of the legislation is that both medical plans and dental plans cover general anesthesia and associated hospital charges when general anesthesia is indicated for dental treatment involving the patients described above.

The health plan must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan, regardless of whether the services are provided in a hospital or dental office.

The act does not prevent the application of standard health plan provisions applicable to other benefits such as deductible or copayment provisions. It does not limit the authority of the Health Care Authority to negotiate rates and contract with specific providers. It does not apply to Medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

SUNRISE PROCESS

The Department of Health conducted an initial public meeting, a formal public hearing, a literature review and legislation in other states. Written comments (including the use of eMail) were accepted from the public through ten days following the public hearing, which was held on November 13, 1998.

The applicant submitted a written report, outlining their proposal according to criteria set forth in RCW 48.47.030. Other interested parties also provided comments (Appendix D) and rebuttals (Appendix H).

Proposals, data and documentation were analyzed according to the criteria provided in statute, with particular attention to issues regarding social and financial impact of the bill and evidence of health care service efficacy.

CURRENT REGULATION AND PRACTICE

In a 1995 membership survey, the American Academy of Pediatric Dentistry estimated the level of public demand for dental treatment under general anesthesia for children under six and the developmentally disabled to be approximately one percent of all pediatric dental patients. Of this one percent of patients, approximately 42 percent are reimbursed through the Medicaid program, while the remaining 58 percent rely on private funding.

According to the Washington State Dental Association, an estimated 28 out of every 1,000 patients receiving dental treatment annual require the use of general anesthesia. Given the above percentages, this would mean that 16 patients out of every 1,000 patients needing dental anesthesia would be privately funded.

The American Academy of Pediatric Dentistry estimates that less than four patients per 1,000 are successful in receiving coverage for general anesthesia, even after appealing the decisions. Those who are successful generally have the sufficient financial and other resources available to sustain the appeal process.

According to the Washington State Dental Association, in Washington State, 300-500 patients annually are denied anesthesia benefits because they received general anesthesia for a dental treatment. Their options are to forgo treatment altogether or until infections and related issues continue to deteriorate and a medical emergency exists, or to receive treatment using conscious sedation and restraint with compromised results.

FINDINGS AND ANALYSES

General

General anesthesia is defined as a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. General anesthesia can be delivered in a hospital environment, surgical center, or properly equipped dental office by appropriately licensed professionals. Training, procedure and equipment requirements for administering general anesthesia in a dental setting are clearly defined in WAC 246-817-770 (see Appendix G).

Young children and patients with severe physical, medical, and/or intellectual disabilities may require general anesthesia because of an inability to comprehend the need for a potentially invasive dental procedure. These patients may feel threatened and become uncooperative or intolerant in their treatment. In these instances, traditional office approaches to delivering necessary dental care are rendered ineffective and may be unsafe to both the patient and practitioner.

General anesthesia is already a benefit for most medical plans. This bill requires that dental treatment for certain age groups, disabilities, or medical conditions be recognized as acceptable indications for general anesthesia, no different than having tubes placed in a child's ears.

Opponents of the bill argue that the bill is too broad because it mandates coverage for any type of anesthesia, whether provided in a dental office or in an inpatient facility. They also argue that age six is an arbitrary number, the language is not restrictive, and that enactment of this legislation may promote utilization of an unnecessary procedure which is not in the best interest of the child.

Very little statistical and financial information or academic research is available regarding mandated benefits for the use of general anesthesia. Therefore, this report relies heavily on the applicant report, testimony and comments received, and information received from other states.

Ten states have mandates for dental anesthesia in place: Minnesota, Tennessee, Texas, Louisiana, Wisconsin, Colorado, Florida, Maryland, Missouri, and New Hampshire. California and Oklahoma have passed legislation which has not yet gone into effect. (See Appendix B)

Social Impact

Medical plans often deny benefits to their policyholders for anesthesia coverage when they seek medically necessary dental care. In instances where a patient has both a medical and dental plan, there is no attempt made by either plan to coordinate benefits. The dental plan may not have anesthesia as part of its policy; the medical plan may offer general anesthesia but denies coverage because of the kind of treatment received is dental in nature.

Consumers expect to be covered for major health care expenses for their children. A family which discovers that the coverage counted upon simply is not there, faces a double dilemma. Not only are they faced with a young or developmentally disabled child in pain and/or needing extensive dental treatment, but are faced additionally with a financial burden that is prohibitive for most families.

Patients and their families are confronted with a financial burden when forced to pay out of pocket for coverage denied by their plan. Treatment is often delayed or forgone because of an inability to pay. Serious health consequences may result, including severe pain, swelling, and in extreme cases, death (i.e. advanced cases of facial cellulitis).

Financial Impact

The average cost of general anesthesia and related hospital expenses in Washington State usually ranges between $3,000 and $4,000. This does not include the cost of dental

treatment. The average cost for anesthesia is $750 to $1,000. Facility fees run from an average of $1,500 for an outpatient surgery center to $3,000 for hospital charges. Some dentists in Washington State are appropriately licensed to administer general anesthesia in a properly equipped office. In these cases, costs are lower.

The applicant provided copies of numerous denial and appeal letters between insurance companies and insureds, which took many hours of time and effort by insurance company employees. Parents, pediatricians, and pediatric dentists write multiple letters of appeal and make numerous time-consuming phone calls, until benefits are finally provided or flatly denied. Inclusion of these benefits to include dental treatment could actually simplify and lessen the administrative costs.

A breakdown of the financial impact in other states is included in Appendix B. However, in other states the scope of the legislation, including the definition of individuals to be covered, varies considerably.

The vast majority of patients requiring dental anesthesia are those already covered by Medicare or the Department of Social and Health Services (DSHS). DSHS reported that of their 467,303 recipients under the age of sixteen, 4,259 required dental anesthesia.

The additional cost to health plans in Washington State should be relatively small because of the few who actually require general anesthesia, but would vary depending upon the number of subscribers. Washington Dental Service estimates an increased cost of $.02 per subscriber per month to provide anesthesia and related coverage.

The Health Care Authority stated that in the absence of documentation of cost assumptions and methods, an independently developed estimate would be required to make a determination of financial impact.

Health Care Efficacy

Evidence presented to the department indicates that failure to treat decayed teeth can result in more expensive and painful treatment, and in a few instances even potentially life-threatening complications. Each year children miss school, have difficulty eating, and suffer needlessly, due to toothaches. Others are seen for emergency care by their pediatricians, family doctors, pediatric and family dentists, and many others are treated in the emergency room or urgent care clinics. These emergency visits are more expensive and often times more traumatic for the patient. In some instances abscessed teeth can lead to such severe infections that hospitalization is required. Preventative and early restorative care under ideal treatment conditions would minimize the likelihood of such problems.

During the public hearing, sample photographs were shown of the teeth of small children with severe caries and infections, attributable to inappropriate baby bottle use or other reasons. A young child has not developed an understanding of the dental office

environment. These children usually need to be restrained while squirming, yelling and screaming throughout the extensive procedure. It is potentially harmful to the child and the results are usually compromised. Left untreated, the dental infection can spread to the cheeks, eyes and jaw, causing a condition called facial cellulitus, from which the complications can be grave, even fatal.

Another example was given at the hearing about a child who required dental care under anesthesia prior to the repair of a congenital heart defect. The dentist determined a significant need for dental care and the necessity to utilize general anesthesia. Despite the obvious medical necessity of dental care, benefits for anesthesia were denied to this patient because the health plan determined it to be a dental procedure and thus outside their coverage.

Additionally, the developmentally disabled may become confused and frightened during a regular dental treatment and become aggressive and violent. Their strength could potentially cause harm or danger to themselves as well as the provider.

RECOMMENDATIONS

The department recommends that general anesthesia be a covered benefit for all state-regulated health plans, if the following modifications and considerations are made prior to enactment of House Bill 2540.

1. Coordination of benefits between medical and dental plans is a potential issue. Therefore, options to consider are:

- Medical plans should cover the cost of general anesthesia and related facility charges when the procedure takes place in a hospital or surgical center environment; dental plans should cover the cost of general anesthesia and related charges when the procedure takes place in a dental office.

2. The definition of covered persons should be more clearly defined

- A child age six or under who is determined by a licensed dentist and the child's physician to require necessary dental treatment in a hospital, ambulatory surgery center or properly equipped dental office due to a significant dental or medical condition; or
- A person who is severely disabled or has a developmental disability in which patient management in the standard dental office has proved to be ineffective; or
- A person who has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital, ambulatory surgical center or properly equipped dental office, provided that such services are delivered upon the recommendation of the patient's physician.

3. Language should be included which would allow managed care plans to require its members to receive care at participating facilities.

4. The term "general anesthesia" should be more clearly defined.

- "A controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command."

SUMMARY OF MAJOR INFORMATION SOURCES

The report of the applicant group (Washington State Dental Association)

The applicant group submitted a thorough report (Appendix C) which addresses all statutory sunrise criteria. It is well-argued and addresses many specific topics not highlighted in this report.

Other supportive testimony

- Health professionals
- Health plans
- Consumer advocates

Summaries of these comments are in Appendix D. Most of the general points made in these comments are addressed and documented in the applicant group's report. The department's panelists felt they received important additional information from the testimony and comments regarding individual, family, and state impacts regarding the lack of coverage of dental anesthesia. The testimony shows evidence of broad interest.

Actuarial and cost impact studies

The review of cost estimates in the applicant report was conducted by the Health Care Authority. The Health Care Authority felt that additional information was needed to conclude if cost estimates were reasonable. A copy of the Health Care Authority letter in Appendix E. Financial impact information from other states was considered and included in Appendix B.

Testimony expressing concerns

There was some testimony expressing concern. (See Appendix D) The Department feels these concerns were fairly considered in the recommendations. Concerns include:

- The definition of covered persons is not clear.

- The act as written would mandate coverage for any type of anesthesia.

- Managed care plans would not be allowed to require members to receive care at a participating facility.

Evidence from other states

Twelve states have passed legislation to mandate coverage for dental anesthesia. Information from other states is included in Appendix B.

Evidence from literature reviewed

Very little information is available regarding coverage of dental anesthesia. An information summary is included in Appendix F.

APPENDIX: A

HOUSE BILL 2540

H-3453.4

HOUSE BILL 2540

State of Washington 55th Legislature 1998 Regular Session

By Representatives Dyer, Cody and Skinner

Read first time . Referred to Committee on .

AN ACT Relating to anesthesia and hospital charges for dental care; adding a new section to chapter 41.05 RCW; and adding a new section to chapter 48.43 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW to read as follows:

(1)(a) Each health plan offered to public employees and their covered dependents under this chapter that is not subject to the provisions of Title 48 RCW and is established or renewed after the effective date of this section, and that provides benefits for hospital or medical care shall provide benefits for anesthesia and hospital charges for dental care for a covered person who: (i) Is a child under age six; (ii) is severely disabled; or (iii) has a medical condition requiring hospitalization or general anesthesia for dental care treatment, provided that such services are delivered upon the recommendation of the patient's physician. Prior authorization may be required in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(b) The health plan must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan, regardless of whether the services are provided in a hospital or a dental office.

(2) This section does not prevent the application of standard health plan provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of the state health care authority to negotiate rates and contract with specific providers. This section does not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1)(a) Every health carrier that provides coverage for hospital or medical expenses shall provide coverage for anesthesia and hospital charges for dental care for a covered person who: (i) Is a child under age six; (ii) is severely disabled; or (iii) has a medical condition requiring hospitalization or general anesthesia for dental care treatment, provided that such services are delivered upon the recommendation of the patient's physician. Prior authorization may be required in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(b) Coverage must also include general anesthesia and treatment rendered by a dentist for a medical condition covered, regardless of whether the services are provided in a hospital or a dental office.

(2) This section does not prevent the application of standard policy provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of an insurer to negotiate rates and contract with specific providers. This section does not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

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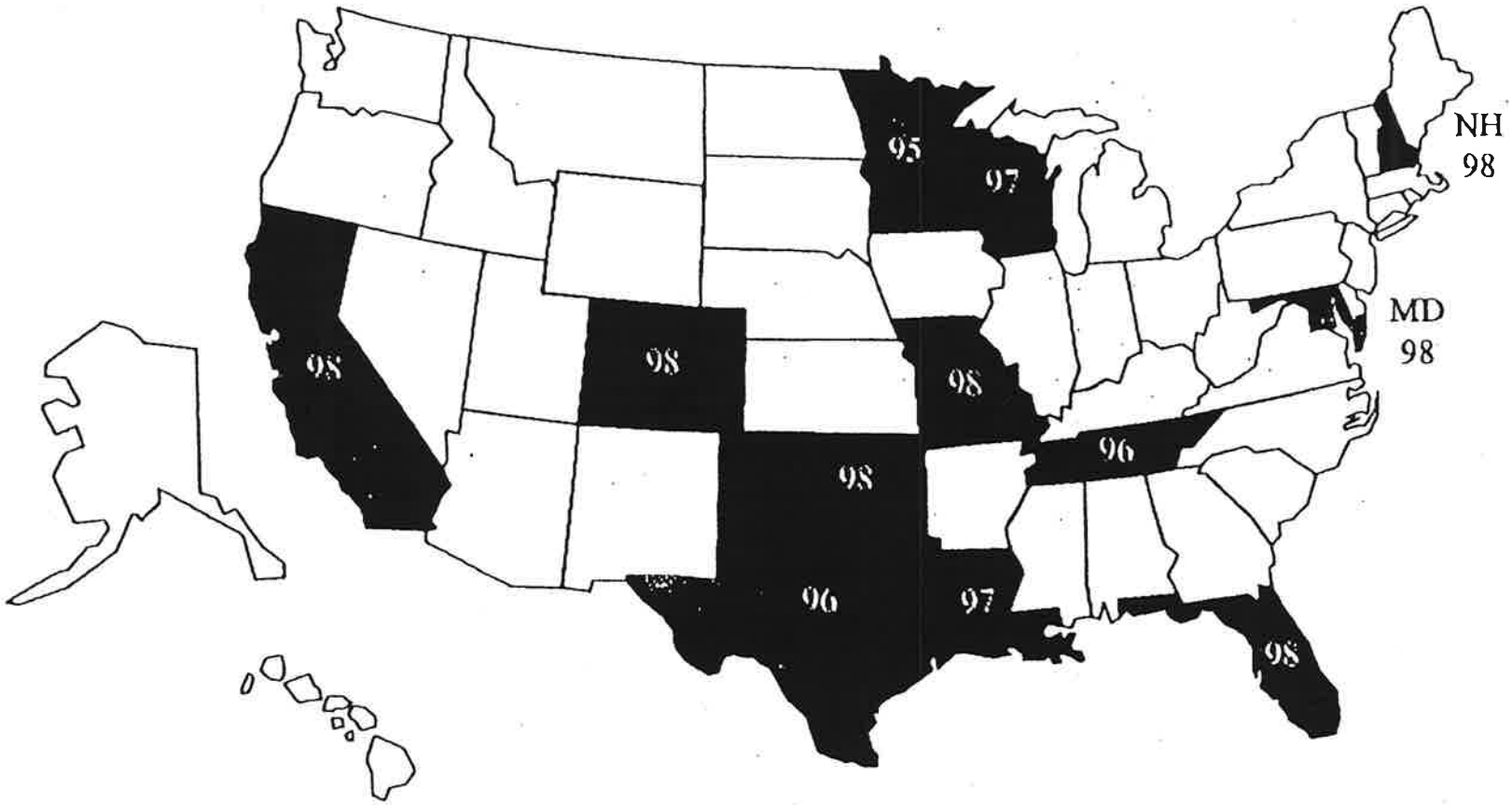
APPENDIX: B

STATES WITH GENERAL ANESTHESIA COVERAGE LEGISLATION

States With General Anesthesia Coverage Legislation



AAPD Dental Care Committee

September 1998

Mandated Health Benefit for Dental Anesthesia

Summarized financial impact from other states

Minnesota

Passage: 1995
New claims following passage of mandate
Average cost of anesthesia
Average related hospital/surgical center costs
Percentage increase in insurance premiums

Texas

Passage: 1996
There has been no measurable financial impact recorded. Blue Cross/Blue Shield of Texas began covering anesthesia and related hospital expenses prior to the mandate in 1996. Since then Blue Cross/Blue Shield of Texas has not found it necessary to raise its premiums.

Louisiana

Passage: 1997

New claims following passage of mandate	500
Average cost of anesthesia and hospital/surgical center costs	$1,700
Percentage increase in insurance premiums	.18%

Wisconsin

Passage: 1997

New claims following passage of mandate	100
Average cost of anesthesia and hospital/surgical center costs	$2,000
Increase in insurance premiums	$.25 per member per month

Maryland

Passage: 1998
Maryland did not complete a financial impact statement. Blue Cross/Blue Shield of Maryland testified before the state legislature that it determined the impact for their subscribers to be $.02-.03 per policy.

Missouri

Passage: 1998	
New claims following passage of mandate	200
Average cost of anesthesia	$750
Average related hospital/surgical center costs	$1,400
Percentage increase in insurance premiums	$.49 per year

California

Passage: 1998	
New claims following passage of mandate	11,500
Average cost of anesthesia and related hospital/surgical center costs	$1,750
Increase in premiums per policyholder	$.93

Mississippi

New claims following passage of mandate	300
Average cost of anesthesia	$600
Average related hospital/surgical center costs	$1,900
Percentage increase in insurance premiums	.042%

Alabama

Passage: 1998	
New claims following passage of mandate	450
Average cost of anesthesia and related hospital/surgical center costs	$2,150
Increase in premiums per policyholder	$.97

STATUTES IN OTHER STATES

California

Beginning January 1, 2000, California requires health plans to cover general anesthesia and associated facility charges for dental procedures for enrollees who are (1) under seven years of age; or (2) developmentally disabled, regardless of age; or (3) whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

A health plan may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

Florida

Florida requires health plans to cover dental anesthesia and hospital charges when dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated. Coverage is provided to a person who (1) is under eight years of age and is determined by a licensed dentist and the child's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or (2) has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

A health carrier may require prior authorization for general anesthesia and hospital services required in the same manner the insurer requires prior authorization for hospitalization for other covered services.

Maryland

Maryland requires health plans to provide coverage for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured if the enrollee or insured is (1) seven years of age or younger or is developmentally disabled; or (2) an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured; and an individual for whom a superior result can be expected from dental care provided under general anesthesia; or (3) an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

The plan may require prior authorization and restrict dental care to that provided by specialists.

Minnesota

Minnesota requires health plans to cover anesthesia and hospital charges for dental care provided to a covered person who (1) is a child under age five; or (2) is severely disabled; or (3)has a medical condition and who requires hospitalization or general anesthesia for dental care treatment.

A health carrier may require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

Coverage for general anesthesia and treatment rendered by a dentist for a medical condition is covered by the plan, regardless of whether the services are provided in a hospital or dental office.

APPENDIX: C

APPLICANT REPORT

WSDA

WASHINGTON
STATE
DENTAL
ASSOCIATION

October 29, 1998

Yvette Lenz
Management Analyst
Health Systems Quality Assurance
Department of Health
1112 Quince Street
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Lenz:

Per our conversation last Monday allow me to clarify what may be confusing language in our applicant report to the sunrise review committee on mandated health insurance benefits.

The original legislation mandated "health plans" cover general anesthesia for dental care when the patient is a child under six, an older patient with developmental disabilities, or a patient with medical conditions requiring hospitalization. We referred to "health plans" in our testimony before the House Health Care Committee during the 1998 legislative session. We also used "health plans" throughout the first public meeting in the sunrise process in July.

Our intention continues to be to have health plans, both medical plans and dental plans, cover general anesthesia and associated hospital charges when general anesthesia is indicated for dental treatment involving the patients described above.

However, in our applicant report we inadvertently use the term "medical plans" at times when the term "health plans" is more appropriate. We are therefore submitting a revised copy of our report indicating where "health plans" is the more appropriate term.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

James Matteucci
Director of Public Affairs

Cc: Lisa Thatcher, Columbia Dental Group

Washington State Department of Health
Mandated Health Insurance Benefits Sunrise Review

Amended Applicant Report

Submitted by the
Washington State Dental Association

The Washington State Dental Association supports legislation mandating ((~~medical~~)) health plan reimbursement for the necessary use of general anesthesia for dental treatment and related hospital expenses for: (i) children under age six (ii) older patients who are developmentally disabled, and (iii) patients with medical conditions requiring hospitalization.

This legislation will increase access to medically necessary dental care for patients that require anesthesia to safely and effectively receive dental care. These patients are often denied coverage because they receive anesthesia for dental rather than medical treatment. Denying coverage on this basis is arbitrary, because the same anesthetic procedure is followed whether it is for a medical or dental treatment.

Patients and their families are confronted with a heavy financial burden when forced to pay out of pocket for coverage denied by their plan. Treatment is often delayed or forgone because of an inability to pay. Serious health consequences may result, including severe pain, swelling, and in extreme cases death.

This legislation does NOT hold medical plans responsible for the cost of dental treatment. It ((~~simply~~)) mandates that medical plans and dental plans reimburse their policyholders ((~~with~~)) for general anesthesia ((~~coverage~~)) and related hospital expenses when they require general anesthesia to receive dental care.

This report will explain the significant health and financial consequences to patients resulting from a denial of benefits when anesthesia is associated with dental treatment. This report will also demonstrate that legislation mandating ((~~medical~~)) health plans reimburse their policyholders in these cases will have a negligible financial impact on the total population of policyholders in Washington state.

At Issue

A small percentage of patients may often feel threatened by an intrusive dental procedure or are unable to comprehend the need to participate in their own dental treatment. As such, they may become intolerant and recoil from a dentist's or hygienist's efforts to deliver care. These patients are generally under six years of age or older patients with developmental disabilities.

A still smaller percentage of patients have medical conditions which present enough risk to require hospitalization before they receive dental care. Examples of such medical conditions include but are not limited to some newly diagnosed cancers, severe cardiac problems, and certain life threatening metabolic disorders.

Anesthesia is often prescribed in these instances so that a patient may receive safe, effective, and timely dental care. However, medical plans often deny benefits to their policyholders with anesthesia coverage when they seek medically necessary dental care. In instances where a patient has both a medical and dental plan, there is no attempt made by either plan to coordinate benefits. The dental plan ((~~does~~)) may not have anesthesia as part of its policy; the medical plan ((~~has~~)) may offer general anesthesia but denies coverage because of the kind of treatment received. Medical plans justify a denial of benefits based on a distinction between the kind of care the anesthesia helped to facilitate.

This distinction is false. The same anestheic procedure is indicated for both medical and dental procedures, whether the procedure is a tonsillectomy, the placement of ear tubes, or the extraction of impacted wisdom teeth.

No credible reason exists why an uncooperative child under six, an older patient with developmental disabilities, or patients with a medical condition requiring hospitalization should be denied coverage otherwise afforded them for a medical treatment. However, a denial of coverage for anesthesia-related expenses forces patients of limited means to delay treatment until faced with a dental emergency resulting from extended decay or infection.

Definition and Protocol for Use

General anesthesia is defined as a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. General anesthesia can be delivered in a hospital environment, surgical center, or properly equipped dental office by appropriately licensed professionals.

Children under six and older patients with severe physical, medical, and/or intellectual disabilities may require general anesthesia because of an inability to comprehend the need for a potentially invasive dental procedure. These patients may feel threatened and become uncooperative or intolerant in their treatment. In these instances, traditional office approaches to delivering necessary dental care are rendered ineffective and may be unsafe to both the patient and the practitioner.

For example, a two-year old child may require treatment for severe and painful caries attributable to inappropriate baby bottle use. At such a young age this child has not yet developed an understanding of the dental office environment and the importance of participating in their dental treatment. Squirming, yelling, crying, even lashing out may make it impossible or unsafe for the child to receive the necessary care.

In another example, a teenager with autism and developmental delay can become confused and frightened during a regular dental treatment. The patient can then become aggressive and violent. Given the relative strength of a teenager under these conditions, it may again be impossible, even dangerous to provide the necessary care.

For these and similar situations, general anesthesia is the recognized and accepted standard of care.

The American Dental Association, the American Academy of Pediatric Dentistry, the American Medical Association, the U.S. Department of Health and Human Services, and most other professional and medical organizations support the use of general anesthesia for dental treatment in these specific situations.

The American Academy of Pediatric Dentistry has developed the following indications for dental treatment under general anesthesia:

1. Patients with certain physical, mental, or medically compromised conditions.
2. Patients with dental needs for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy.
3. The extremely uncooperative, fearful, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred.
4. Patients who have sustained extensive orofacial and dental trauma.
5. Patients with dental needs who otherwise would not obtain necessary dental care.
6. Patients requiring dental care for whom the use of general anesthesia may protect the developing psyche.

Furthermore, the American Dental Association, in a statement supported by the American Academy of Pediatric Dentists, defines medically necessary care as:

Medically necessary care means the reasonable and appropriate diagnosis, treatment and follow-up care (including supplies, appliances, and devices) as determined by qualified, appropriate health care providers in treating any condition, illness, disease, injury, or birth development malformations. Care is medically necessary for the purpose of controlling or eliminating infection, pain, disease, and restoring facial disfiguration or function necessary for swallowing or chewing.

Dental treatment that is medically necessary as defined above should not trigger the exclusion of medical insurance benefits payable for general anesthesia when these benefits would otherwise be available under the policy's provisions. This legislation provides increased access to care for these patients.

Social Impact

In a 1995 membership survey, The American Academy of Pediatric Dentistry estimated the level of public demand for dental treatment under general anesthesia for children under six and the developmentally disabled to be approximately 1percent of all pediatric dental patients. Of this 1percent of patients, approximately 42 percent are reimbursed through the Medicaid program, while the remaining 58 percent rely on private funding. Similarly, the Medi-Cal program in California, which provides medically necessary general anesthesia coverage for Denti-Cal patients, estimates its utilization rate to be 0.23 percent.

In Washington State, an estimated 28 out of every 1,000 patients receiving dental treatment annually require the use of general anesthesia. Again, a percentage of these 28 patients are privately funded; others receive coverage via the Medicaid program.

It is important to note that the Medicaid program mandates qualifying patients have direct access to dental care under general anesthesia when the appropriate criteria for

need are met. In effect, this legislation will provide private patients the same level of access to care available to those on public assistance.

Three hundred to five hundred patients annually in Washington state are denied their anesthesia benefits because they received general anesthesia for a dental treatment. These patients face two options: they can forgo treatment, which means dental infection and related issues continue to deteriorate until a medical emergency requires more significant and costly treatment and can be potentially life threatening. They can receive treatment via the use of passive restraints, though only for brief treatments. Or, in limited situations, they can receive treatment outside the guidelines for care accepted by both the dental and medical communities and the U.S. Department of Health and Human Services through the use of physical restraint involving additional personnel. However, physically restraining a patient is only moderately effective and can only be done for procedures that are short in duration. There is an obvious danger to everyone involved when patients are forced to receive dental treatments this way.

When pediatric dentists were asked about the outcomes of cases for which general anesthesia was warranted but not provided because of a denial of benefits, they indicated that when alternative strategies were available, they were not routinely successful. In only 40 percent of cases did conscious sedation or other approaches to treatment provide comparable results. Approaches that at least completed treatment but produced compromised results succeeded only 34percent of the time.

More significant and discouraging, however, is that pediatric dentists reported the decision to defer treatment or forgo treatment altogether resulted in a serious increase in dental disease 31 percent of the time.

While there are isolated examples of patients receiving coverage, the American Academy of Pediatric Dentistry estimates that less than 25 percent of patients are successful, even after maneuvering through the often protracted and confusing appeal process. Those who are successful generally have the sufficient financial and other resources available to sustain the appeal process. This legislation protects those without the necessary resources and does away with this unnecessary pursuit altogether.

Financial Impact

Legislation mandating ((~~medical~~)) health plan reimbursement for general anesthesia and related hospital expenses will NOT increase the total cost of health care or hold the medical plan responsible for the cost of the dental treatment.

Ten states currently have this mandate in place: Minnesota, Tennessee, Texas, Louisiana, Wisconsin, and added this year were Colorado, Florida, Maryland, Missouri, and New Hampshire.

Insurance Commissioners in some of these states have attempted to calculate the extent to which this additional coverage impacts insurance premiums. In Minnesota, where coverage has been mandated since 1995, the Insurance Commissioner has been unable to identify any financial impact. Mississippi's Insurance Commissioner has been able to determine only a nominal impact: 0.042 percent of premium dollars. Other states have indicated a potential financial impact of $.01-.03 per premium life covered each month.

Washington Dental Service, the state's leading dental insurance company, has estimated the monthly cost for its enrollees to be just $.02 per subscriber. WDS supports this legislation and does not perceive it to be financially burdensome.

But while the financial impact to the state's premium holders is inconsequential, the financial barrier to care for patients denied general anesthesia coverage is may be both financially and physically traumatic. The average cost of general anesthesia and related hospital expenses in Washington state regularly exceeds $3,000, and can exceed $4,000 or more for extensive cases involving multiple teeth. Broken down this means the average cost for anesthesia is $750-1,000. An average facility fee for the hospital or surgery center is $1,500-3,000.

Because dentists with the appropriate licensing can in certain cases administer general anesthesia in a properly equipped dental office, these costs are sometimes lower. However, a majority of cases, especially those involving severe dental infection, are completed in a hospital setting.

Patients who are denied coverage and do not have the means to pay out of pocket are forced to decide whether to delay treatment until faced with a dental emergency—at which time the costs will be even higher—or pursue alternative sources, such as credit cards and bank loans.

Medical Efficacy

The contribution this legislation will bring to the quality of patient care and overall health status can be measured only by viewing oral health as an integral component of a patient's overall health. Arbitrary insurance distinctions should not separate the oral cavity from the rest of the body.

Compromised oral health hinders, sometimes dramatically, an older patient's ability to find or maintain employment. Severe dental pain may prevent a patient from performing at work. Additionally, when a child has untreated dental disease and infection and is unable to maintain proper nutrition because of an inability to chew and eat, the child's overall health suffers.

For example, Children's Hospital of Seattle has approximately 26 admissions annually for children suffering from facial cellulitus, a condition which can result from extensive dental infection that spreads from the teeth to the cheeks to the eyes and jaw leading to swelling and severely compromised health. Untreated dental caries and delayed care are the most common causes in these cases. The deterioration is so severe that the only proper and effective means to deliver the necessary dental treatment is with the use of general anesthesia. The charges for dental treatment in these instances range from $2,700 to $6,300. If left untreated past the stage of facial cellulitus, the complications can be grave.

Mandating ((~~medical~~)) health plan coverage for general anesthesia and related hospital expenses for these and other necessary treatments will provide these patients with the same standard of care provided to the Medicaid-eligible or the privately insured.

Conclusion

This legislation will provide access to medically necessary dental care for patients under six, those with developmental disabilities, and with medical conditions requiring hospitalization. It will eliminate the false distinction made by medical plans that deny coverage for general anesthesia provided for a dental treatment. As a result, this legislation will eliminate the unfair position patients or their guardians face when having to pay out of pocket for coverage otherwise available to them for a medical treatment.

To be clear, this mandate does NOT seek coverage of dental treatments by medical plans. This mandate only seeks coverage by health plans for the general anesthesia and related hospital expenses incurred during a dental treatment for patients under six, with developmental disabilities, and those with medical conditions requiring hospitalization.

This legislative mandate will

- provide access to medically necessary dental care under general anesthesia for children under six, the developmentally disabled, and patients with medical conditions requiring hospitalization.
- cover less than one percent of the population receiving dental care in Washington state.
- have a negligible impact on insurance premiums.
- not impact the total cost of health care.

WSDA

WASHINGTON
STATE
DENTAL
ASSOCIATION

December 1, 1998

Yvette Lenz
Management Analyst
Health Systems Quality Assurance
Department of Health
1112 Quince Street
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Lenz:

Thank you for the opportunity to respond to questions raised during the November 13, 1998, public hearing regarding mandated health benefit coverage of anesthesia delivered for dental care.

We believe the age of children this legislation would affect should be "six years and younger." As Dr. Bryan Williams indicated, children over the age of six have generally matured to a level at which they become more cooperative in their dental care. However in some extreme cases relative to children six and under with severe dental decay, it is difficult for the patient to comprehend the need for invasive and potentially painful dental procedures. Although alternative approaches exist for delivering care to these children, they most often produce inferior results as previously indicated. General anesthesia is the accepted standard of care in these situations.

The panel was asked who would make the determination of whether a patient's disability, medical condition, or behavior is severe enough to require anesthesia. We believe the dentist should make the determination of when treatment approaches and management techniques have been exhausted, proven ineffective or unsafe for the patient and thus require general anesthesia for the effective delivery of dental care. Oftentimes a physician completes a physical examination of the patient to determine if there is any corollary health condition likely to effect the patient under deep sedation.

In some instances a physician may request a dental exam prior to proceeding with a medical procedure to ensure the absence of dental decay and possibility of infection. In cases such as these the physician will consult with a dentist, who will make a determination of whether dental care is required to prevent infection and whether it will require general anesthesia.

General anesthesia is not always indicated for these cases. However for some it is the only available option. We provided the panel with one such case in which a child required dental care under anesthesia prior to the repair of a congenital heart defect. The dentist determined a significant need for dental care and the necessity to utilize general anesthesia. Despite the obvious medical necessity of dental care, benefits for anesthesia were denied to this patient because the health plan determined it to be a dental procedure and thus outside their coverage.

A panel member asked whether any noticeable consistency exists in health plans denying or approving anesthesia benefits for dental care. All five dentists present at the hearing indicated a lack of any clear justification for approving or denying anesthesia benefits for dental care. Dr. Dan Davidson elaborated that this inconsistency exasperates the dilemma facing these patients and their families who need to make the necessary treatment decisions and financial arrangements.

Furthermore, it is difficult for us to provide you with an accurate percentage of approved versus denied claims because of these inconsistent coverage decisions. All five pediatric dentists stated that denials occurred "more than 75-80 percent of the time" in their practices. This is consistent with the findings of the American Academy of Pediatric Dentistry. And while this may be a high percentage it still does not provide any indication of a health plan's predicted action, because plans are known to have denied and approved benefits for different patients confronting the same need.

I would like to stress Drs. Bertha Barriga and Dale Ruemping's point that this mandate <u>will not</u> create an incentive for dentists to use general anesthesia. Dentists approach the use of general anesthesia with serious caution based on the oral health needs and long term well being of the patient. In most instances alternative approaches have been exhausted or produce inferior results that do not resolve the patient's condition. As Dr. Barriga stated, "not many people require anesthesia for their dental care but those that do need it badly."

In states where this mandate has been in effect for several years the average per year utilization increase has been 300-500. Blue Cross/Blue Shield of Louisiana, Texas, and Maryland each decided that mandated coverage of anesthesia for dental care would have a negligible utilization impact to their respective states. Washington Dental Service, the largest dental insurer in Washington, testified to the same.

Since the public hearing you have requested information about the potential financial impact of this mandate relative to medical plans. A summary from several states that currently have this mandate in effect is attached. I believe you will find a strong consistency across the country indicating a negligible, in some cases immeasurable financial impact. Their findings are also consistent with estimates from the Washington State Academy of

Pediatric Dentistry, Children's Hospital and Medical Center, and the Washington Dental Service.

I hope this information will be helpful to you as you draft your report. Please call me should you have any further questions or require additional information.

Sincerely,

James Matteucci
Director of Public Affairs

Ken Bertrand, Group Health Cooperative
Nancy Wildermuth, PacifiCare
Sean Pickard, Washington Dental Service
Suzy Tracy, Washington State Medical Association

APPENDIX: D

INFORMATION SUMMARY

INFORMATION SUMMARY

(Information is summarized and paraphrased from written documents and oral testimony. No interpretation has been made. It has only been edited for brevity.

For the applicant, Dentistry for Children and Adolescents, Del R. Pietscher, DDS, MS

The demand for this hospital coverage is dependent on the dental population and the area of the state being served, but when viewed as a whole the expense to the insurance companies is negligible. I support the bill as written and oppose any potential restrictions imposed by the insurance companies regarding the amount of dental treatment needed, location of services performed, etc. These issues are within the professional opinion of the provider.

From October 1997 through October 1998, I have completed 243 hospital cases, 90 of which had insurance coverage. Of the 90, we experienced 23 denials for hospital coverage. The outcomes are as follows:

1	Treatment was completed in the office
4	Obtained DSHS coverage
3	Filed appeals but proceeded with treatment at parents expense
2	Filed appeals and denial reversed
13	Patient treatment is unknown

For the applicant, Dr. Dale Ruemping, Spokane

Dentists do not view this mandate as an opportunity to increase their usage of deep sedation with patients. It is only in cases where the patient cannot effectively receive proper care or is unable to comprehend the need for an invasive dental procedure. This occurs with children six and under and older patients with severe disabilities.

While this is not a large patient population it is a group of patients that generally have no other option. Sometimes dentists attempt alternative approaches to care, such as restraints. I use the term "rodeo dentistry" because trying to treat an uncooperative patient without sedation is hit and miss and can be very dangerous to both the patient and the dental team. In my office and others, we often have difficulty completing a set of x-rays and photos of these patients because of their inability to cooperate. Alternative approaches commonly have inferior and incomplete results.

This mandate will allow access to care for the small group of patients that require general anesthesia for dental care. Many patients disappear once they have been denied benefits because they are unable to pay out of pocket. We can only assume that these patients have forgone care until it becomes a medical emergency, at which time their medical plan will provide coverage or the patient goes to the emergency room. In both cases the impact to the patient's health is more severe and the overall costs are significantly higher.

Other states where this mandate is in effect demonstrated that the financial impact is negligible. It is estimated to be only pennies per policyholder in Washington State.

Washington Dental Service, Sean Picard

The proposed mandated benefit is not financially burdensome. Washington Dental Service (WDS) estimates that is would cost $.02 per subscriber per month to provide the coverage mandated by the proposed legislation. WDS evaluated current cost to existing groups that provide similar coverage as mandated by the legislation. The method of analysis was to take information that was available from the groups currently opting for similar coverage and apply that data on average to out entire book of business.

The WDS analysis is based solely on current group benefit policies, not individual benefit policies. Additional assumptions were no change in provider practice patterns associated with the benefit; no change in provider average fee for the benefit; and all data is based on current WDS experience, which includes anesthesia and related charges, not hospitalization.

Based upon current WDS group experience over the last year:

- 35 percent of subscribers currently have benefits similar to those mandated by the legislation
- .5 percent of the total procedures claimed by all subscribers from the above groups were considered similar to the benefits mandated by the legislation, approximately 11,500 claims
- 363 claims for anesthesia procedures to children under eight years of age were experienced out of nearly 2 million overall claims for the above groups
- .02 percent to .04 percent of the groups cost was for coverage similar to those mandated by the legislation

When projected to WDS's overall book of business:

- 65 percent of business would have the additional anesthesia coverage
- 760 additional anesthesia claims for children under 8 could be expected for a given year
- $110 is the projected average claim cost
- $.01 would be the projected cost per subscriber, per month, for the entire book of business, based on the current data

Kaiser/Group Health, Mary P. Weiler, J.D. Director, Regulatory Services

The proposed legislation, as written, concerns Kaiser/Group Health in a number of ways. First, the language is ambiguous and overly broad. The proposed act as written mandates coverage under medical benefits for **any** type of anesthesia, whether provided in a dental office or in an inpatient facility. Lidocaine and nitrous oxide are frequently provided in a dental office, and the act, as written, would require that medical plans reimburse for such expenses.

In addition, the proposed act mandates coverage for children under age five. Children under age five do not "defacto" require anesthesia and hospitalization for dental procedures. Enactment of this proposed legislation may promote utilization of an unnecessary procedure which may actually be harmful or not be in the best interests of the child.

The act also mandates coverage for persons who are "severely disabled" or have "medical condition requiring hospitalization." These terms are not defined and it is unclear who is responsible for making such determinations.

The act does not distinguish between traditional indemnity plans and managed care plans. It would not allow managed care plans to require its members to receive care at a participating facility. If the act were amended to allow managed care plans to require that care be received at a participating facility, would they be required to grant any dentist hospital privileges? Would the managed care plan be forced to reimburse for services received from any qualified provider?

Health carriers **do not** cover anesthesia and hospital expenses for conditions which are excluded, such as purely cosmetic procedures. Enactment would begin mandating coverage for all non-covered procedures.

The act provides that coverage must include anesthesia and treatment rendered by a dentist for a medical condition. Under what circumstances is it appropriate for a dentist to provide care for medical conditions?

The applicant report clarified intentions to include both medical and dental plans as subject to the act, stating that the financial impact will not increase the total cost of health care, and that in Minnesota, the Insurance Commissioner has been unable to identify any financial impact. However, in Alabama, to guarantee coverage for dental procedures performed in an inpatient facility would increase costs 97 cents per policy holder.

The added costs of this act on dental plans would likely dramatically increase the per member per month cost, especially since the costs would be spread over a much smaller pool.

If both medical and dental plans were mandated to provide such coverage, persons with both medical and dental coverage would receive a windfall through coordination of benefits. Both plans would be considered primary absent additional language and individuals would receive double reimbursement for such expenses.

Columbia Dental of Washington, Inc., Cyndy Harrison, Government Programs/Quality Improvement Coordinator

We recognize that certain populations require general anesthesia in a hospital or ambulatory surgery center in order to provide necessary dental treatment. However, mandating treatment to be covered by both medical and dental plans, especially for a service that is argued to be needed by only a small percentage of the population, increases premiums for everyone. This often leads to employers increasing the employee's out of pocket expenses or even dropping benefits altogether. This is especially true in dental coverage, as it is often seen as more discretionary than medical coverage is. This reduces access to dental coverage and thus reduces access to dental care.

Our concerns with the mandate are highlighted below:

Proposed covered population: Language in other state mandates is more clearly defined and sets limits on the actual persons who could be covered under the mandate. The age of six is an arbitrary number. Language should be more restrictive, such as New Hampshire's "a child under the age of four who is determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or hospital setting." Florida's language includes "require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective, or has one or medical conditions that would create significant of undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital setting or ambulatory surgical center."

Other states mandated language: Most states that enacted a mandate, mandated that medical plans, not dental plans, cover the dental anesthesia and related costs, so those states cost estimates would be based on medical plan premiums, not dental plan premiums. The Washington State Dental Association uses financial impact information from Minnesota which mandates that the medical plans provide coverage, not the dental plans, The actual financial impact reports from other states were not included in the WSDA's applicant report. New Hampshire required dental plans to provide coverage for dental anesthesia only when performed in the dental setting. Language used in other states that mandate coverage vary widely, such that comparison of cost analysis would not be accurate. Minnesota even required that medical plans pay for anesthesia performed in the dental office.

Financial impact: The financial impact on dental premiums can be assumed to be higher, especially for smaller plans who have fewer lives to spread the cost over, because there is no real experience to base premiums on. In addition, WDS states that their estimates do not include the associated hospital costs of ambulatory surgery center costs. They also assume that current practice patterns would not change, however, it should be assumed that if providers know that a service is a mandated benefit, that more providers will request approval for the benefit. Also, the requests for coverage that are denied by medical plans would not be included in determining plan experience. Most medical plans already have established negotiated relationships with hospitals and ambulatory surgical centers, which reduced the costs associated with providing care in the hospital. Dental plans do not have these relationships, and do not have the leverage to negotiate these types of contracts. Dental plans who subcontract with medical plans would have to pass cost of increased premiums onto the medical plan. Dental plans would have to apply copayments to the general anesthesia services and associated hospital costs in order to recoup expenses (most dental procedures, other than orthodontia, are not above $1,000 per procedure.) These copayments are likely to be very high and could be just as cost prohibitive to patients as the full fees were. This would not increase access to these services.

Cost benefit analysis: Costs are based upon the process quoted in the applicant report. We do not have prior experience with payment of general anesthesia in the hospital or associated hospital costs with which to base a cost benefit analysis. Oregon Medicaid numbers are used and are based on the number of hospital cases performed in a year, identified by our payment of the associated treatment. Medical plans are mandated to cover the general anesthesia and associated hospital costs, so the frequency assumption made in our cost benefit analysis is less than the actual Medicaid frequency. Assuming that WSDA's numbers are accurate, we could experience an increase in premiums anywhere from $.50 to $1.59 per member per month. This increase would have a negative impact on small dental plan's ability to compete with larger plans. This competitive disadvantage would leave less consumer choice in the state.

APPENDIX: E

HEALTH CARE AUTHORITY'S ANALYSIS

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

676 Woodland Square Loop S.E., P.O. Box 42682 • Olympia, Washington 98504-2682
(360) 923-2600 • FAX (360) 923-2609 • TDD (360) 923-2701

November 12, 1998

Mr. Steve Boruchowitz, Health Policy Analyst
Health Systems Quality Assurance
Sunrise Review Panel
Washington State Department of Health
P.O. Box 47851
Olympia, Washington 98504-7851

Dear Mr. Boruchowitz:

The Health Care Authority (HCA), pursuant to chapter 48.47.030 RCW, has conducted a review of the proposed dental anesthesia legislation.

The HCA did not use the services of our consulting actuary due to resource limitations. This is consistent within the scope of the agreement with the Department of Health regarding assignment of priority to reviews. HCA's technical and fiscal staff conducted a review and made the determination explained below.

The review resulted in an indeterminate opinion. While the proposal was compelling in its qualitative aspects, it did not contain a sufficient base of assumptions or a description of the methods utilized to arrive at the cited cost estimates. Without documented assumptions and methods, an independently developed cost estimate would be required. The HCA is unable to accomplish any further analysis of this proposal due to resource constraints, and is in accordance with the priority assigned to this proposal per our interagency agreement.

Although this review resulted in an indeterminate opinion, enclosed are the findings and observations made by HCA's technical and fiscal staff. The HCA is willing to conduct an additional technical review if the Department of Health would like to resubmit the proposal. Additional attachments that contain more detailed cost estimates and assumptions from the proponent would need to be included.

Thank you for allowing the HCA to review this proposal. If you have any questions regarding this review, please feel free to contact me at (360) 923-2828 or Beth Berendt at (360) 923-2728.

Sincerely,

Gary L. Christenson
Administrator

GLC:jal
Enclosure
cc: Beth Berendt

bcc: Beau Bergeron
Juan Alaniz
Judy Francis
Lisa Laux
Connie Clark

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

676 Woodland Square Loop S.E., P.O. Box 42682 • Olympia, Washington 98504-2682
(360) 923-2600 • FAX (360) 923-2609 • TDD (360) 923-2701

November 12, 1998

TO: Gary L. Christenson
Administrator

FROM: Beth Berendt, Assistant Administrator
Health Plan Management

SUBJECT: Mandated Benefits Review: Dental Anesthesia

The Health Care Authority (HCA) Mandated Benefits Review Committee has made an **indeterminate opinion** regarding the proposed dental anesthesia legislation. The HCA did not employ the services of our consulting actuary due to resource limitations. This is consistent within the scope of the agreement with the Department of Health on assignment of priority and resources to reviews.

There were no assumptions provided or a description of the methods utilized to arrive at the cited cost estimates. In keeping with the priority and resources assigned to this proposal for review, no further analysis will be accomplished at this time. In the absence of documentation of cost assumptions and methods, an independently developed estimate would be required.

The HCA should extend an offer of an additional technical review if the Department of Health would like to resubmit the proposal. Additional attachments that include more detailed cost estimates and assumptions from the proponent would need to be included.

While the review was deemed indeterminate, HCA's technical and fiscal staff made the following observations:

Assumptions:

1. Assumptions used to develop this estimate are not included in the proposal. Proponents base their financial impact estimate on the Washington Dental Service estimate of $.02 per subscriber per month. The source of the statistics regarding cost of hospitalization for dental procedures is not provided.

2. No information was provided disclosing the percentage of health plans currently providing benefits for hospital facility charges associated with these services. The projected per member per month cost may be affected if the majority of carriers do not currently reimburse for these services and the additional cost of facility fees is not factored in the calculation. There is no breakdown in the components used to price the benefit, and costs derived from other states are not itemized.

On the Proposed Bill:

1. Requires carriers to recognize dentists on the same basis as medical doctors for services rendered to treat *medical* conditions in either the hospital or dentist's office, provided the condition and service are covered by the health plan. A cost estimate to price this component does not appear to have been accomplished and was not provided.

2. This bill will require a health plan which covers hospital-only or medical-only benefits to include the scope of benefits. Health plans not including hospital benefits will have to establish reimbursement systems, and hospital coverage-only plans will have to enter the professional provider business. There was no cost analysis to price this component.

3. The Public Employees Benefits Board (PEBB) medical plan minimum benefit covers treatment by a licensed dentist in the office for most accidental injuries to sound, natural teeth. PEBB dental plans include coverage for hospitalization and anesthesia necessary for dental services identified within the scope of this bill when the services are not covered by an employer-sponsored medical plan. The proposed bill results in *shifting* costs to the medical plans.

4. This bill does not establish an order of benefit payment when a person is covered by both a medical and dental plan (when dental plans include the coverage described in the bill). Double coverage may create a financial incentive for inpatient treatment as double coverage could result in increased utilization of services. This potential and its cost impact was not addressed.

Proposal:

1. This proposal relies partially on Medicaid programs for analysis. Medicaid includes dental coverage; although, the actual dental procedures are covered through other mechanisms besides managed care (FFS). These plans are priced accordingly. The specific population cited may not be representative of the Washington State population and may not be as reliable as a source of data.

2. Private medical health plans sometimes include dental as part of an integral benefit package which would then mimic Medicaid. It is likely that coverage for facility fees and dental anesthesia would be covered in a benefit package of this kind. These plans could be an additional source of data, and may be more representative of the population in this state being impacted by this bill.

3. Medical plans routinely exclude dental procedures. Some provide coverage for repair of injury to sound, natural teeth. Medical plans also routinely exclude services delivered in conjunction with any excluded service, thereby, excluding coverage for dental anesthesia. This bill could place medical plans in the business of paying for ancillary charges for noncovered services. Medical necessity is not considered when services delivered in conjunction with a noncovered service or condition are denied. This is true of dental *and* medical services.

4. The proposal cites a low-end average cost of hospitalization as $3,000, low-end average anesthesia fee as $750, and low-end average facility fee as $1,500. The composition of the remaining charges of $750 are not addressed. It is not known if these charges might be those that relate to a physician monitoring the hospitalization. These remaining charges do not seem to be within the scope of coverage anticipated by the proposed legislation.

BB:jal

APPENDIX: F

LITERATURE REVIEW

LITERATURE REVIEW

American Academy of Pediatric Dentistry, Access to Hospital Care 1995 Membership Survey, October 1995

Recognizing the need to gain greater access to the hospital for the very young and special needs patient for whom dental care in a traditional office setting is inappropriate, the academy conducted a membership survey to determine the extent, basis and implications of the problem. The responses are summarized below:

Eighty four percent reported providing dental care under general anesthesia. Of these dentists, 93 percent provide general anesthesia in a hospital or outpatient surgery center, while six percent provided general anesthesia in the dental office. However, the number of patients treated under general anesthesia was only one percent of pediatric dental patients. Of these, 42 percent were Medicaid funded and the remaining were private cases.

The reason given by parents or other responsible parties for declining care under general anesthesia when is was recommended or proposed for their child was the cost associated with the hospital and the general anesthesia. Sixty-one percent of these parents had no medical insurance, and 41 percent had medical insurance but were denied benefits.

When asked to estimate the outcome of cases where coverage was not provided, the response indicated that alternate strategies are not available to provide routinely successful outcomes. Conscious sedation or other approaches provided comparable results 40 percent of the time; other approaches that accomplished treatment with a compromised result occurred 34 percent of the time; and deferral of treatment with subsequent increase in dental disease, or the complete lack of treatment, occurred 31 percent of the time.

Asked if cost were not an issue, 48 percent of responding pediatric dentists indicated they would recommend care under general anesthesia more frequently, and 52 percent felt that their recommendations would continue unchanged. Eighty three percent estimated that parental acceptance would increase if cost were not a prohibitive barrier.

Most patients had no benefits available under their medical insurance.

Anesthesia and Sedation in the Dental Office, National Institutes of Health Consensus Development Conference Statement

For adults, general anesthesia in an office setting may be contraindicated in patients who are not healthy. These individuals demand special consideration, which may require treatment in the hospital or a similar setting.

For pediatric patients, dentists need a cooperative and quiescent patient for the rendering of high quality care, which is a prime indication for the use of sedation or general anesthesia. Pediatric patients with extensive and complicated treatment needs, with acute pain and/or trauma, as well as those who are physically disabled or mentally retarded, may require sedation of general anesthesia. At times, the very young child and those with limited or compromised ability to comprehend and communicate also are candidates for such procedures.

Additionally, there may be an indication for sedation of general anesthesia when the child would be better served by increasing the length of the appointment time and thus reducing the number of visits to accomplish the required treatment.

APPENDIX: G

WAC 246-817-770

saturation must be continuously monitored and recorded at appropriate intervals throughout any period of time in which purposeful response of the patient to verbal command cannot be maintained. The patient's level of consciousness shall be recorded prior to the dismissal of the patient and individuals receiving these forms of sedation must be accompanied by a responsible individual upon departure from the treatment facility. When verbal contact cannot be maintained during the procedure, continuous monitoring of blood oxygen saturation is required.

(2) Equipment and emergency medications: All offices in which parenteral or multiple oral sedation is administered or prescribed must comply with the following recordkeeping and equipment standards:

(a) Dental records must contain appropriate medical history and patient evaluation. Dosage and forms of medications dispensed shall be noted.

(b) Office facilities and equipment shall include:

(i) Suction equipment capable of aspirating gastric contents from the mouth and pharynx.

(ii) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen-enriched patient ventilation and oral and nasal pharyngeal airways of appropriate size.

(iii) A blood pressure cuff (sphygmomanometer) of appropriate size and stethoscope; or equivalent monitoring devices.

(iv) An emergency drug kit with minimum contents of:

-Sterile needles, syringes, and tourniquet
-Narcotic antagonist
-A and B adrenergic stimulant
-Vasopressor
-Coronary vasodilator
-Antihistamine
-Parasympatholytic
-Intravenous fluids, tubing, and infusion set
-Sedative antagonists for drugs used if available.

(3) Continuing education: A dentist who administers conscious parenteral or multi-agent oral sedation must participate in eighteen hours of continuing education or equivalent every three years. The education must include instruction in one or more of the following areas: Venipuncture, intravenous sedation, physiology, pharmacology, nitrous oxide analgesia, patient evaluation, patient monitoring, medical emergencies, basic life support (BLS), or advanced cardiac life support (ACLS).

(4) A permit of authorization is required. (See WAC 246-817-175 for training requirements.)

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-760, filed. 10/10/95, effective 11/10/95.]

WAC 246-817-770 General anesthesia (including deep sedation). Deep sedation and general anesthesia must be administered by an individual qualified to do so under this chapter.

(1) Training requirements for monitoring personnel: In addition to those individuals necessary to assist the practitioner in performing the procedure, a trained individual must be present to monitor the patient's cardiac and respiratory functions. The individual monitoring patients receiving deep sedation or general anesthesia must have received a minimum of fourteen hours of documented training in a course specifically designed to include instruction and practical experience in use of all equipment required in this section. This must include, but not be limited to, the following equipment:

(a) Sphygmomanometer;
(b) Pulse oximeter;
(c) Electrocardiogram;
(d) Bag-valve-mask resuscitation equipment;
(e) Oral and nasopharyngeal airways;
(f) Defibrillator;
(g) Intravenous fluid administration set.

A course, or its equivalent, may be presented by an individual qualified under this section or sponsored by an accredited school, medical or dental association or society, or dental specialty association.

(2) Procedures for administration: Patients receiving deep sedation or general anesthesia must have continual monitoring of their heart rate, blood pressure, and respiration. In so doing, the licensee must utilize electrocardiographic monitoring and pulse oximetry. The patient's blood pressure, heart rate, and respiration shall be recorded at least every five minutes. During deep sedation or general anesthesia, the person administering the anesthesia and the person monitoring the patient, may not leave the immediate area.

During the recovery phase, the patient must be monitored continually by an individual trained to monitor patients recovering from general anesthesia or deep sedation. A discharge entry shall be made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.

(3) Equipment and emergency medications: All offices in which general anesthesia (including deep sedation) is administered must comply with the following recordkeeping and equipment standards:

(a) Dental records must contain appropriate medical history and patient evaluation. Anesthesia records shall be recorded during the procedure in a timely manner and must include: Blood pressure, heart rate, respiration, blood oxygen saturation, drugs administered including amounts and time administered, length of procedure, any complications of anesthesia.

(b) Office facilities and equipment shall include:

(i) An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient.

(ii) An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for the administration of basic life support.

(iii) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure.

(iv) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A backup suction device must be available.

(v) An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system.

(vi) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater.

(vii) Ancillary equipment which must include the following:

(A) Laryngoscope complete with adequate selection of blades, spare batteries, and bulb.

(B) Endotracheal tubes and appropriate connectors.

(C) Oral airways.

(D) Tonsillar or pharyngeal suction tip adaptable to all office outlets.

(E) Endotracheal tube forceps.

(F) Sphygmomanometer and stethoscope.

(G) Adequate equipment to establish an intravenous infusion.

(H) Pulse oximeter.

(I) Electrocardiographic monitor.

(J) Synchronized defibrillator available on premises.

(c) Drugs. Emergency drugs of the following types shall be maintained:

(i) Vasopressor.

(ii) Corticosteroid.

(iii) Bronchodilator.

(iv) Muscle relaxant.

(v) Intravenous medications for treatment of cardiac arrest.

(vi) Narcotic antagonist. Sedative antagonist, if available.

(vii) Antihistaminic.

(viii) Anticholinergic.

(ix) Antiarrhythmic.

(x) Coronary artery vasodilator.

(xi) Antihypertensive.

(xii) Anticonvulsant.

(4) Continuing education: A dentist granted a permit to administer general anesthesia (including deep sedation) under this chapter, must participate in eighteen hours of continuing education every three years. A dentist granted a permit must maintain records that can be audited and must submit course titles, instructors, dates attended, sponsors, and number of hours for each course every three years. The education must be provided by organizations approved by the DQAC and must be in one or more of the following areas: General anesthesia, conscious sedation, physical evaluation, medical emergencies, monitoring and use of monitoring equipment, pharmacology of drugs and agents used in sedation and anesthesia, or basic life support (BLS), or advanced cardiac life support (ACLS).

(5) A permit of authorization is required.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-770, filed 10/10/95, effective 11/10/95.]

WAC 246-817-780 Mandatory reporting of death or significant complication. If a death or other life-threatening complication or permanent injury which may be a result of the administration of nitrous oxide, conscious sedation, deep sedation or general anesthesia, the dentist involved must submit a written report to the DQAC within thirty days of the incident.

The written report must include the following:

(1) Name, age, and address of the patient.

(2) Name of the dentist and other personnel present during the incident.

(3) Address of the facility or office where the incident took place.

(4) Description of the type of sedation or anesthetic being utilized at the time of the incident.

(5) Dosages, if any, of drugs administered to the patient.

(6) A narrative description of the incident including approximate times and evolution of symptoms.

(7) Additional information which the DQAC may require or request.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-780, filed 10/10/95, effective 11/10/95.]

WAC 246-817-790 Application of chapter 18.130 RCW. The provisions of the Uniform Disciplinary Act, chapter 18.130 RCW, apply to the permits of authorization that may be issued and renewed under this chapter.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-790, filed 10/10/95, effective 11/10/95.]

SUBSTANCE ABUSE MONITORING PROGRAMS

WAC 246-817-801 Intent. It is the intent of the legislature that the DQAC seek ways to identify and support the rehabilitation of dentists where practice or competency may be impaired due to the abuse of drugs including alcohol. The legislature intends that these dentists be treated so that they can return to or continue to practice dentistry in a way which safeguards the public. The legislature specifically intends that the DQAC establish an alternate program to the traditional administrative proceedings against such dentists.

In lieu of disciplinary action under RCW 18.130.160 and if the DQAC determines that the unprofessional conduct may be the result of substance abuse, the DQAC may refer the license holder to a voluntary substance abuse monitoring program approved by the DQAC.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-801, filed 10/10/95, effective 11/10/95.]

WAC 246-817-810 Terms used in WAC 246-817-801 through 246-817-830. "Aftercare" is that period of time after intensive treatment that provides the dentist or the dentist's family with group or individual counseling sessions, discussions with other families, ongoing contact and participation in self-help groups, and ongoing continued support of treatment and/or monitoring program staff.

"Approved substance abuse monitoring program" or "approved monitoring program" is a program the DQAC has determined meets the requirements of the law and the criteria established by the DQAC in the Washington Administrative Code which enters into a contract with dentists who have substance abuse problems regarding the required components of the dentist's recovery activity and oversees the dentist's compliance with these requirements. Substance

APPENDIX: H

REBUTTAL STATEMENT

COLUMBIA
Dental Group

Mailing Address
101 S. 336th Street, Suite C-100
Federal Way, WA 98003

All Appointments • 1-800-360-8019
Administration • 1-800-360-1909
FAX • 206-838-8077

January 27, 1999

Yvette Lenz
Department of Health
PO Box 47851
Olympia, WA 98504-7851

By FAX: 360-236-4626

RE: Dental Anesthesia Sunrise Review

Dear Yvette:

Thank you for the opportunity to review and respond to the final draft of the Dental Anesthesia Sunrise Review report. The Department of Health's recommendations appear fair and reasonable. It also addresses the shared concerns of narrowing the scope of this bill and clearly defining terms.

We would like to reiterate our concerns regarding mandates for insurance coverage. Dental coverage is still considered discretionary and is very sensitive to any premium increase. The financial impact to dental plans was never fully investigated and the impact a mandate may have on dental plans, large and small, remains uncertain. Even Washington Dental Service has indicated that their analysis did not include the true ambulatory surgery centers or hospitals costs for anesthesia and that they had no actual experience.

It should be highlighted to anyone reviewing this proposed legislation that other states that have passed mandates have done so mostly through the medical plans, which is why the premium costs have been expressed as only costing $.01 per member per month. Any experience that they have would not be applicable to the impact on dental coverage.

I want to thank you again for the opportunity to provide feedback. If you need any additional information please feel free to contact me at 1-800-360-1909 ext. 4392 or contact our legislative representative Lisa Thatcher at 253-209-1638.

Sincerely,

Cyndy Harrison

Cyndy Harrison
Government Programs and Quality Improvement Coordinator

c: Lisa Thatcher

Dodger